Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
P O BOX 11586
HOUSTON TX 77293

Carrier's Austin Representative Box
19

MFDR Date Received
AUGUST 16, 2005

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-05-B414-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not pay claim at usual & customary."

Amount in Dispute: $27,830.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 2, 2005: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $3,837.07 represents an amount greater than or equal to the fair and reasonable reimbursement for this service…Carrier calculated the reimbursement based upon an agreement/contract with the Requestor."

Response Submitted by: Flahive, Ogden & Latson, P. O. Drawer 13367, Austin, TX 78711

Respondent's Position Summary Dated September 29, 2005: "Review of the supplemental documentation, reveals this was an inpatient admission and has not been billed properly. The Claimant was admitted on 11/10/04 at 11:55 hours. Discharge was 11/11/04 at 17:40 hours."

Response Submitted by: Flahive, Ogden & Latson, P. O. Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
November 10, 2004 Through November 11, 2004	Inpatient Hospital Services	$27,830.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- * 04814 – *UNBUNDLING
- * 04835 – *DENIAL AFTER RECONSIDERATION
- W1 – Workers Compensation State Fee Schedule Adjustment.
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $1,088.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $1,455.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $10.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $100.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $115.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $120.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $13.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $14,678.36
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $155.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $179.12
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $18,421.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $2,388.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $240.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $243.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $3,406.46
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $30.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $320.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $10.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $41.26
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $528.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $57.85

- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $60.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $608.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $64.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $690.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $77.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $78.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $780.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $80.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $88.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $88.40
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $90.00
- 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. $96.00
- BILL NOTES: REDUCED ACCORDING TO USUAL AND CUSTOMARY RATES OBTAINED BY QMEDTRIX. PLEASE CONTACT QMEDTRIX DIRECTLY WITH ANY QUESTIONS OR CONCERNS REGARDING THE REDUCTIONS AT 1-800-833-1993.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Does this dispute meet the criteria of outpatient hospital services as billed?
3. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 24 – "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(b)(1)(B) states "Inpatient Services—Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the submitted documentation revealed the disputed services were billed as an outpatient hospital stay, however, the length of stay exceeded 23 hours. The division concludes that the disputed services did not meet the criteria of outpatient hospital services, however, the disputed services did meet the criteria of inpatient hospital services.

3. 28 Texas Administrative Code §134.401(c)(1) states "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401 (c)(2)(A) states "All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical and surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401 (c)(3)(A)(i and ii) states "Each admission is assigned an admission category indicating the primary service(s) rendered

(medical or surgical). The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission."

4. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was one day. The surgical per diem rate of $1,118 multiplied by the length of stay of one day results in an allowable amount of $1,118.00.

   The division concludes that the total allowable for this admission is $1,118.00 per diem. The respondent issued payment in the amount of $3,887.07. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. As a result no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 1, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	November 1, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.